Date: _____

RE: Letter of Medical Necessity for the No BS Weightloss Program for FSA/HSA reimbursement

To whom it may concern,

This letter is written to provide information about the membership of _____ who started our weight loss program on _____.

The No BS Weightloss Program is a weight loss program and monthly membership subscription. Members pay $289 for the first month and then $59 per month thereafter until they cancel.

As a Certified Master Weight and Life Coach from The Life Coach School, I created the No BS Weightloss Program to teach women how to lose both their physical and mental weight. The focus is on learning how to eat according to your body and how to change your relationship with food. Members learn to eat when they are physically hungry and stop when they are satisfied. The program does not use diets, calorie counting, or food restriction. Coaching focuses on the habits and thoughts that lead to overeating, such as emotional and habitual eating.

The courses help women lose weight through:

- realistic planning
- listening to their physical hunger sensations
- prioritizing sleep and water
- redefining their view on their ability to lose weight

Members receive:

- **The No BS Course:** a step-by-step course on habits, mindset, and long-term weight management.
- **Weekly live group coaching** with certified life and weight loss coaches.
- **Monthly courses** on topics such as nighttime snacking, emotional eating, mindful drinking, and the holidays.
- **A private member community** for support and accountability.

For information about our program, visit www.nobsweightloss.com/fsa-and-insurance.

Sincerely,

CORINNE CRABTREE
Founder & CEO

Letter of Medical Necessity

This letter serves as a prescription and letter of medical necessity for the patient referenced below, currently being treated for obesity or overweight with one or more health consequences.

To be filled out by patient:

Patient Name:	
Sex:	
DOB:	
Address:	
Phone:	
SS# **(optional)**:	
Physician:	
Phone:	
Fax:	

To be filled out by physician regarding patient listed above:

Date:		
Height:		
Weight:		
BMI:		
BMI Weight Class:	Normal Overweight Obese Extremely Obese	
I refer this patient because of diagnosis of...	___ Morbid Obesity ___ Type 2 Diabetes ___ Hypercholesterolemia ___ Impaired Glucose Tolerance ___ Other (list): _____	___ Obesity ___ Hypertension ___ Mixed Hyperlipidemia ___ Sleep Apnea

Physician Comments:

_____

_____

Physician Signature: _____ Date: _____

Patient should keep this letter for tax purposes as proof necessary for reimbursement under an FSA, HRA, or Health Insurance Coverage Plan.